

✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1502

08105

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Elliott City

City or town.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 M6.

Hospital, institution, or street address where death occurred:

PINELL CLINIC

How long in hospital or institution?

3. (a) FULL NAME

SOPHIE BLEIBERG

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Widower

6. (b) Name of husband or wife... Rev. BENJ.

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

RUSSIA

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

FATHER

12. Name

BOROCH -

13. Birthplace

Russia

MOTHER

14. Maiden name

BESSIE -

15. Birthplace

Russia

16. Informant

JACOB J. EDELMAN

Address

16146 WYNNS FALLS PKWY

17. BURIAL

Date thereof 8-15-45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

UNITED HEBREW GEMS

Location

ASHINGTON BLVD.

18. Funeral director

JACK LEWIS, INC

Address

1439 E. BALTO. ST

19. (Date rec'd by registrar)

8/15/45

City Health

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County

City or town BALTO. "

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3604 SEMUGIA AXE

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 13 1945 at 7P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 10 1945, to Aug. 13 1945
and that I last saw her alive on Aug. 13 1945

Immediate cause of death

Cerebral Hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Jean A. Koslow, MD

M. D. or other

Address Elliott City, Md Date signed 8/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-14

CERTIFICATE OF DEATH

68196

195

Reg. Dist. No.

1. PLACE OF DEATH: Howard
County.....

City or town..... Savage (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME Bertha Condon

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Emery Condon

7. Birth date of deceased (mo. day. yr.) Nov 23 - 1890 6.(c) If alive, give age 61 years

8. AGE: Years 56 Months 9 Days 2 If less than one day
hrs. min.

9. Birthplace Va. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Thomas F. Hilt

12. Name Thomas F. Hilt

13. Birthplace Va.

14. Maiden name Mary F. Jenkins

15. Birthplace Va.

16. Informant Emery Condon

Address Savage Md

17. Burial Burial Date thereof Aug 26-45
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Savage

Location Savage Md

18. Funeral director Gold Lasser

Address Savage Md

19. (Date rec'd by registrar) 8/27/45 Registrars signature Frank Shiley

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)

State Md. County Howard

City or town Savage (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1945 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 12 - 45 Aug. 13 - 45 Aug. 14 - 45 Aug. 15 - 45 Aug. 16 - 45 Aug. 17 - 45 Aug. 18 - 45 Aug. 19 - 45 Aug. 20 - 45 Aug. 21 - 45 Aug. 22 - 45 Aug. 23 - 45 Aug. 24 - 45 Aug. 25 - 45 Aug. 26 - 45 Aug. 27 - 45 Aug. 28 - 45 Aug. 29 - 45 Aug. 30 - 45 Aug. 31 - 45 Aug. 32 - 45 Aug. 33 - 45 Aug. 34 - 45 Aug. 35 - 45 Aug. 36 - 45 Aug. 37 - 45 Aug. 38 - 45 Aug. 39 - 45 Aug. 40 - 45 Aug. 41 - 45 Aug. 42 - 45 Aug. 43 - 45 Aug. 44 - 45 Aug. 45 - 45 Aug. 46 - 45 Aug. 47 - 45 Aug. 48 - 45 Aug. 49 - 45 Aug. 50 - 45 Aug. 51 - 45 Aug. 52 - 45 Aug. 53 - 45 Aug. 54 - 45 Aug. 55 - 45 Aug. 56 - 45 Aug. 57 - 45 Aug. 58 - 45 Aug. 59 - 45 Aug. 60 - 45 Aug. 61 - 45 Aug. 62 - 45 Aug. 63 - 45 Aug. 64 - 45 Aug. 65 - 45 Aug. 66 - 45 Aug. 67 - 45 Aug. 68 - 45 Aug. 69 - 45 Aug. 70 - 45 Aug. 71 - 45 Aug. 72 - 45 Aug. 73 - 45 Aug. 74 - 45 Aug. 75 - 45 Aug. 76 - 45 Aug. 77 - 45 Aug. 78 - 45 Aug. 79 - 45 Aug. 80 - 45 Aug. 81 - 45 Aug. 82 - 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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08117

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County.....

City or town.....

*Howard
Ellicott City*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*7 yrs*

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Eva May Cross

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife

Harry Lee Cross

7. Birth date of deceased (mo., day, yr.)

Aug. 3, 1888

8. AGE:

Years

Months

Days

It less than one day

57

—

15

hrs.

min.

9. Birthplace

West Philadelphia, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

FATHER

12. Name

George H. Redgely

13. Birthplace

West Philadelphia, Md.

MOTHER

14. Maiden name

Matilda Gaither

15. Birthplace

Sykeville, Md.

16. Informant

Harry Lee Cross

Address

Ellicott City, Md.

17. Burial

Date thereof *Aug. 21, 1945*

(Burial, cremation, or removal. Which?)



08108

M PLEASE WRITE PLAINLY, WITH ~~INK~~ FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. **195**

1. PLACE OF DEATH:
County *Hagerstown* **City or town** *Hagerstown* **(If outside city or town limits, write RURAL and give nearest town)**
How long in above place of death? *74 yrs.* **Hospital, Institution, or street address where death occurred:** _____

How long in hospital or institution? *1*

3. (a) FULL NAME *Charles Edward Shantz*

4. Sex <i>M.</i>	5. Color or race <i>W.</i>	6. (a) Single, married, widowed, or divorced <i>Married</i>
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6. (b) Name of husband or wife *Wanda J. Shantz*

7. Birth date of deceased (mo., day, yr.) *Feb. 17 1874* **(b.c) If alive, give age** *years*

8. AGE: **Years** *73* **Months** *5* **Days** *26* **If less than one day** _____
hrs. _____ **min.** _____

9. Birthplace *Clark* **(Town, county, and state)**

10. Usual occupation. *clerk*

11. Industry or business *Gloves*

MOTHER FATHER

12. Name <i>Jack A. Shantz</i>
13. Birthplace <i>Brooklyn Co. N.Y.</i>
14. Maiden name <i>Mary Spence</i>
15. Birthplace <i>Brooklyn Co. N.Y.</i>

16. Informant *Mrs. E. A. Shantz*

Address *Savage, Md.*

17. Burial **Date thereof** *Aug. 13 1945* **(Burial, cremation, or removal. Which?)** *Burial* **(month) (day) (year)**

Cemetery or crematory *Savage Md.*

Location *Savage Md.*

18. Funeral director *Hecht & Sonnleitner*

Address *Savage Md.*

19. (Date rec'd by registrar) *8/13/45* **Frank Shantz** **Registrar**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State *Md.* **County** *Howard*
City or town *Savage* **(If outside city or town limits, write RURAL and give nearest town)**
Street No. _____ **(If rural, give LOCATION)**

2.(a) If veteran, name war _____

3. (b) Social Security Number *217-01-7914-R*

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 11th 1945 at 9 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Feb. 17 1945* **to** *Aug. 11 1945* **and that I last saw him alive on** *Aug. 11 1945* **at** *9 P.M.*

Immediate cause of death *Myocardial infarct* **DURATION** *1 month.*

Due to *Arterio-sclerosis* **-** *4 yrs.*

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ **Date of op.** _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ **Date of** _____

Where did injury occur? _____ **(City or town)** _____ **(County)** _____ **(State)**

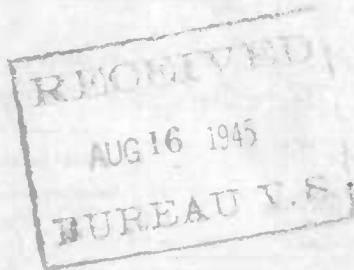
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ **Injured at work?** _____

23. SIGNATURE *Frank Shantz, M.D.* **M. D. or other** _____
Address *Savage, Md.* **Date signed** *8/13/45*

1945
1878
73

20.
45
73



1945
74
1878
13